WEEKLY BULLETIN

Communicable disease threats report

Week 9, 21–27 February 2026

This week's topics

Executive Summary

Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

- Since 1 January 2026, and as of 25 February 2026, 25 714 cholera cases, including 282 deaths, have been reported worldwide.
- Since 28 January 2026, and as of 25 February 2026, 24 009 new cholera cases, including 275 new deaths, have been reported worldwide.
- The five countries reporting the most cases are Afghanistan (9 460), the Democratic Republic of the Congo (9 325), Mozambique (2 267), Yemen (1 626), and Burundi (382).
- The five countries reporting the most new deaths are the Democratic Republic of the Congo (219), Mozambique (34), Zambia (7), Afghanistan (4), and Angola (4).
- Cholera cases have continued to be reported in Africa, Asia, the Middle East, and the Americas. The risk of cholera infection in travellers visiting these countries remains low, even though sporadic importation of cases to the EU/EEA is possible.

European Centre for Disease Prevention and Control, Solna, Sweden
www.ecdc.europa.eu

Overview of respiratory virus epidemiology in the EU/EEA

Summary

Primary care consultations for respiratory illness have returned to baseline levels in half of reporting countries, indicating that respiratory virus circulation has declined across much of the EU/EEA over the past weeks.

Influenza virus circulation, while still widespread, continues to decrease in most countries, with around half now reporting baseline or low levels of intensity. Hospitalisations also continue to decrease, with adults aged 65 years and above accounting for most admissions. Influenza A(H3) remains the dominant subtype, followed by A(H1)pdm09.

Respiratory syncytial virus (RSV) circulation remains high, but has shown a slight decline over the past two weeks. This downward trend has not yet been observed in RSV hospitalisations, where children under five years continue to account for most admissions.

SARS-CoV-2 circulation remains low in all age groups, with very few hospitalisations reported.

EuroMOMO reported all-cause mortality was above expected levels from weeks 1–7 of 2026 across all age groups, but recent weeks show a decline from the week 2 peak.

All data are provisional and may be affected by reporting delays, incomplete country data or low testing volumes. A few countries with high testing rates can disproportionately influence pooled data. Further information is available under 'Country notes' and 'Additional resources'.

Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

- Since the previous update and as of 26 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.
- The Winter Olympic Games Milano Cortina 2026 finished on 22 February. During the mass gathering event, no major public health events related to communicable diseases were detected. Limited outbreaks were reported among athletes related to gastrointestinal and influenza-like illnesses.
- The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied.

Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

- A high number of travel-related cases of chikungunya virus disease has been reported among travellers returning to Europe from Seychelles since late 2025, indicating intense ongoing transmission in the country.
- The current likelihood of chikungunya virus infection for travellers to Seychelles is high. Travellers should be advised to take enhanced mosquito bite prevention measures. Vaccination of travellers may be considered, based on national recommendations.
- A news item has been published in the ECDC website: High number of chikungunya cases reported among travellers returning from Seychelles: local transmission in mainland Europe currently unlikely.

Human cases of influenza virus A(H1N1) variant of swine origin - Multi-country

- In February, authorities in Spain reported a confirmed human case of swine influenza A(H1N1)v.
- A total of four human cases of swine influenza A(H1N1)v have been reported from Spain in the last 17 years (since 2009). The last case was reported in 2024.
- Based on the information currently available, the likelihood of further transmission of variant A(H1N1) linked to this event is assessed to be very low.

1. Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update

Overview:

Data presented in this report originate from several sources, both official public health authorities and non-official sources, such as the media. Case definitions, testing strategies, and surveillance systems vary between countries. In addition, data completeness and levels of under-reporting vary between countries. All data should therefore be interpreted with caution. For details on the epidemiological situation and more information regarding the case definitions in use, refer to the original sources.

Update

Since 28 January 2026, and as of 25 February 2026, 24 009 new cholera cases, including 275 new deaths, have been reported worldwide.

New cases have been reported from Afghanistan, Angola, Burundi, the Democratic Republic of the Congo, Malawi, Mozambique, Myanmar/Burma, Namibia, Nigeria, Pakistan, Somalia, Sudan, Yemen, Zambia, and Zimbabwe.

The five countries reporting most cases are Afghanistan (9 460), the Democratic Republic of the Congo (9 325), Mozambique (2 267), Yemen (1 626), and Burundi (382).

New deaths have been reported from Afghanistan, Angola, Burundi, the Democratic Republic of the Congo, Mozambique, Nigeria, Yemen, Zambia, and Zimbabwe.

The five countries reporting most new deaths are Democratic Republic of the Congo (219), Mozambique (34), Zambia (7), Afghanistan (4), and Angola (4).

In the previous reporting period (24 December 2025 to 28 January 2026), 11 965 new cholera cases, including 126 new deaths, were reported worldwide.

In addition, 735 new cases were reported or collected retrospectively from before 28 January 2026.

Since 1 January 2026, and as of 25 February 2026, 25 714 cholera cases, including 282 deaths, have been reported worldwide. In comparison, since 1 January 2025, and as of 25 February 2025, 69 088 cholera cases, including 709 deaths, were reported worldwide.

Since the last update, new cases and new deaths have been reported from:

Asia:

Afghanistan:
Since 28 December 2025, and as of 9 February 2026, 9 460 new cases, including four new deaths, have been reported. Since 1 January 2026, and as of 9 February 2026, 9 460 cases, including four deaths, have been reported. In comparison, in 2025 and as of 24 February 2025, 14 403 cases, including six deaths, were reported.
Myanmar/Burma:
Since 28 December 2025, and as of 9 February 2026, 120 new cases have been reported. Since 1 January 2026, and as of 9 February 2026, 120 cases have been reported. In comparison, in 2025 and as of 20 January 2025, 553 cases were reported.

Pakistan:
Since 28 December 2025, and as of 19 January 2026, 493 new cases have been reported. Since 1 January 2026, and as of 19 January 2026, 493 cases have been reported. In comparison, in 2025 and as of 10 February 2025, 4 038 cases were reported.

Yemen:

Since 28 December 2025, and as of 9 February 2026, 1 626 new cases, including one new death, has been reported. Since 1 January 2026, and as of 9 February 2026, 1 626 cases, including one death, has been reported. In comparison, in 2025 and as of 24 February 2025, 10 080 cases, including 10 deaths, were reported.

Since 28 January 2026, no updates have been reported by India, Nepal, or the Philippines.

Africa:

Angola:
Since 27 January 2026, and as of 18 February 2026, 46 new cases, including four new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 198 cases, including six deaths, have been reported. In comparison, in 2025 and as of 18 February 2025, 3 147 cases, including 108 deaths, were reported.

Burundi:
Since 27 January 2026, and as of 18 February 2026, 382 new cases, including two new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 405 cases, including two deaths, have been reported. In comparison, in 2025 and as of 24 February 2025, 95 cases were reported.

Democratic Republic of The Congo:
Since 31 December 2025, and as of 18 February 2026, 9 325 new cases, including 219 new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 9 325 cases, including 219 deaths, have been reported. In comparison, in 2025 and as of 17 February 2025, 8 056 cases, including 171 deaths, were reported.

Malawi:
Since 27 January 2026, and as of 18 February 2026, 53 new cases have been reported. Since 1 January 2026 and as of 18 February 2026, 65 cases, including two deaths, have been reported. In comparison, in 2025 and as of 18 February 2025, 83 cases, including two deaths, were reported.

Mozambique:
Since 27 January 2026, and as of 18 February 2026, 2 267 new cases, including 34 new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 3 163 cases, including 37 deaths, have been reported. In comparison, in 2025 and as of 3 February 2025, 64 cases were reported.

Namibia:
Since 27 January 2026, and as of 18 February 2026, two new cases have been reported. Since 1 January 2026, and as of 18 February 2026, 20 cases have been reported. In comparison, in 2025 and as of 25 February 2025, no cases were reported.

Nigeria:
Since 31 December 2025, and as of 18 February 2026, 251 new cases, including three new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 251 cases, including three deaths, have been reported. In comparison, in 2025 and as of 24 February 2025, 1 124 cases, including 28 deaths, were reported.

Somalia:
Since 27 January 2026, and as of 18 February 2026, 241 new cases have been reported. Since 1 January 2026, and as of 18 February 2026, 323 cases have been reported. In comparison, in 2025 and as of 17 February 2025, 1 409 cases, including one death, was reported.

Sudan:
Since 31 December 2025, and as of 11 January 2026, nine new cases have been reported. Since 1 January 2026, and as of 11 January 2026, nine cases have been reported. In comparison, in 2025 and as of 18 February 2025, 2 437 cases, including 53 deaths, were reported.

Zambia:
Since 27 January 2026, and as of 18 February 2026, 231 new cases, including seven new deaths, have been reported. Since 1 January 2026, and as of 18 February 2026, 236 cases, including seven deaths, have been reported. In comparison, in 2025 and as of 18 February 2025, 224 cases, including nine deaths, were reported.

Zimbabwe:
Since 31 December 2025, and as of 18 February 2026, five new cases, including one new death, has been reported. Since 1 January 2026, and as of 18 February 2026, five cases, including one death, has been reported. In comparison, in 2025 and as of 18 February 2025, 133 cases, including two deaths, were reported.

Since 28 January 2026, no updates have been reported by Cameroon, Chad, Comoros, Congo, Côte D'Ivoire, Ethiopia, Ghana, Kenya, Rwanda, South Sudan, Togo, Uganda, or the United Republic of Tanzania.

Americas:
No new cases or new deaths have been reported.

ECDC assessment:

Cholera cases have continued to be reported in Africa and Asia, the Middle East, and the Americas.

In this context, although the likelihood of cholera infection for travellers visiting these countries remains low, sporadic importation of cases to the EU/EEA is possible.

In the EU/EEA, cholera is rare and primarily associated with travel to endemic countries. In the EU/EEA, all cholera cases were reported annually; and since 2024, only events of locally-acquired cholera cases are reported. Global imported and locally-acquired cholera cases are reported to the World Health Organization (WHO) on an annual basis. In 2024, 16 imported cases were reported by eight EU/EEA countries, while 12 were reported in 2023, 29 in 2022, two in 2021, and none in 2020. In 2019, 25 cases were reported in EU/EEA countries (including the United Kingdom). All cases had a travel history to cholera-affected areas.

According to WHO, vaccination should be considered for travellers at higher risk of infection, such as emergency and relief workers who may be directly exposed. Vaccination is generally not recommended for other travellers. Travellers to cholera-endemic areas should seek advice from travel health clinics to assess their personal risk and apply precautionary sanitary and hygiene measures to prevent infection. Such measures can include drinking bottled water or water treated with chlorine, carefully washing fruit and vegetables with bottled or chlorinated water before consumption, regularly washing hands with soap, eating thoroughly cooked food, and avoiding the consumption of raw seafood products.

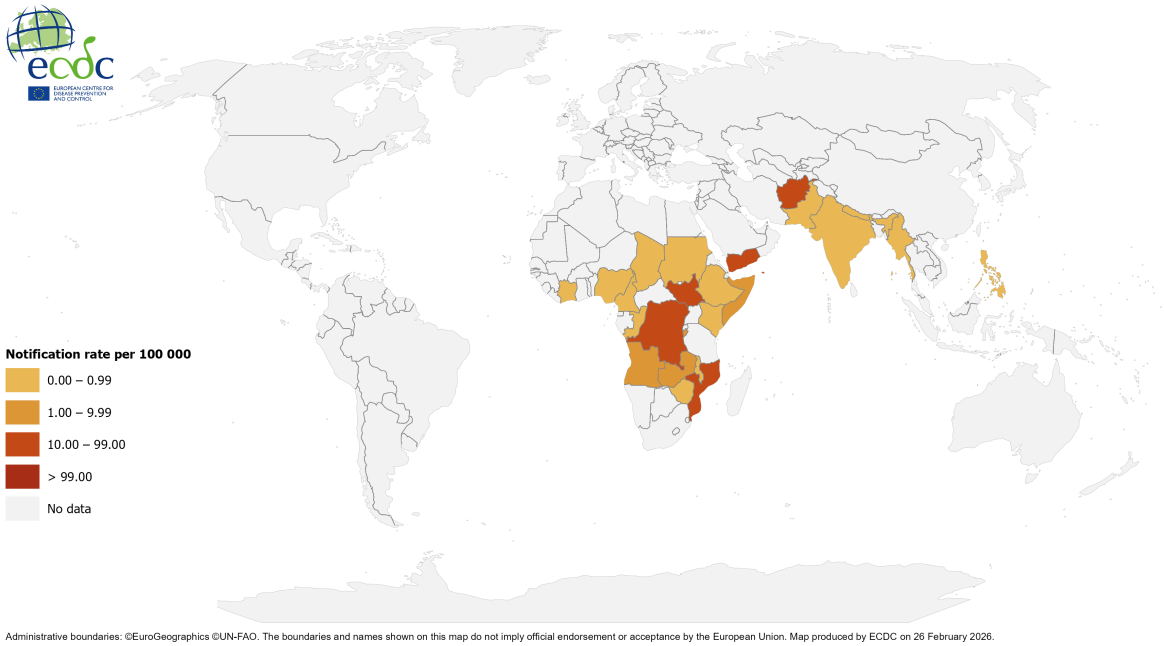
Actions:

ECDC continues to monitor cholera outbreaks globally through its epidemic intelligence activities in order to identify significant changes in epidemiology and provide timely updates to public health authorities.

Reports are published on a monthly basis. The worldwide overview of cholera outbreaks is available on ECDC's website.

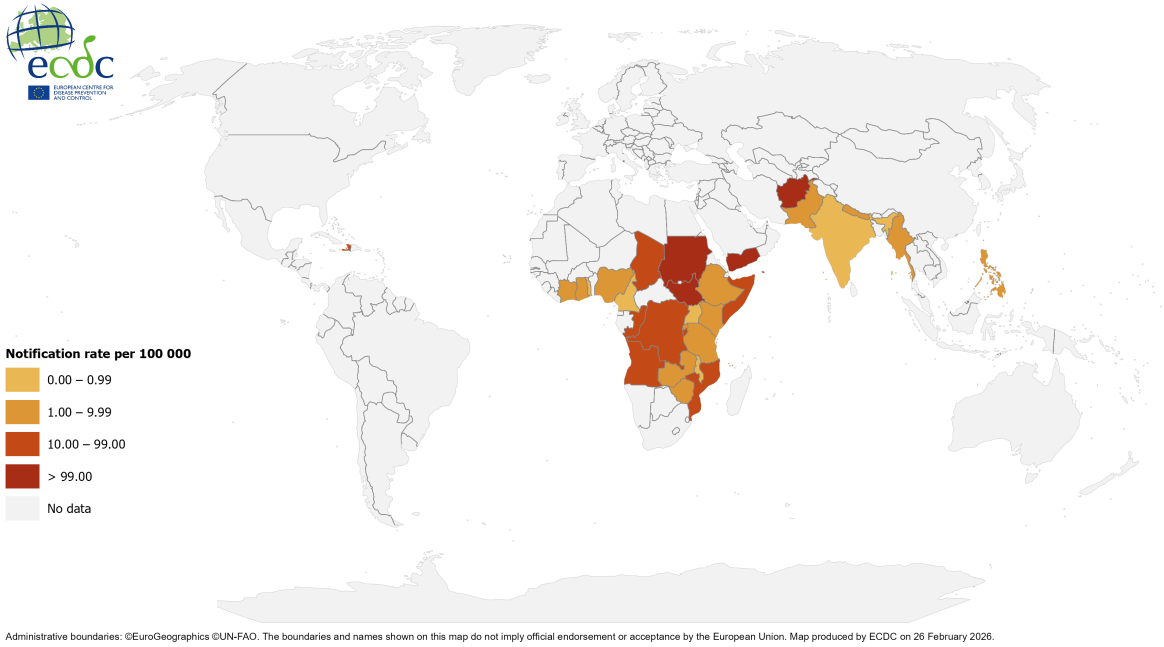
Last time this event was included in the Weekly CDTR: 30 January 2026

Figure 1. Geographical distribution of cholera cases reported worldwide from December 2025 to February 2026



Source: ECDC

Figure 2. Geographical distribution of cholera cases reported worldwide from February 2025 to February 2026



Source: ECDC

2. Overview of respiratory virus epidemiology in the EU/EEA

Overview:

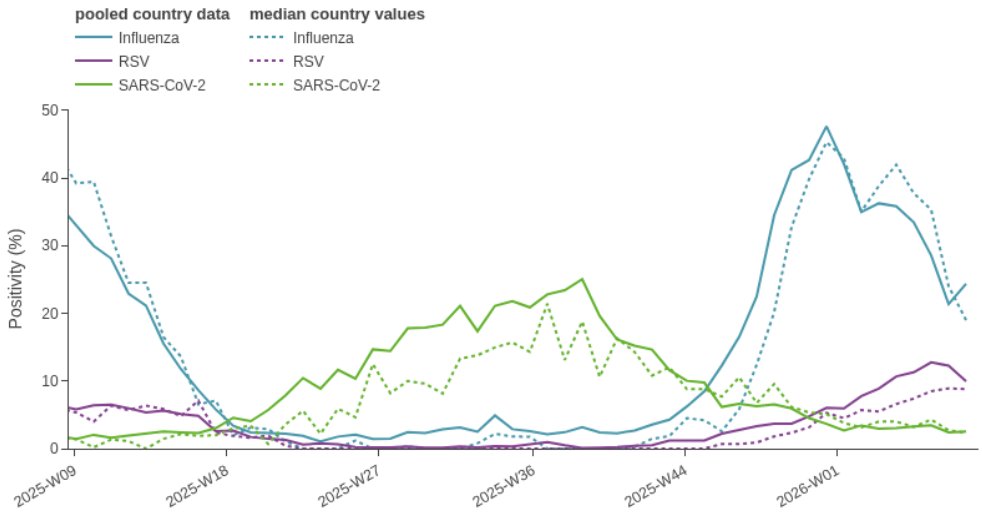
ECDC monitors respiratory illness rates and virus activity across the EU/EEA. Findings are presented in the European Respiratory Virus Surveillance Summary (ERVISS.org), which is updated weekly.

Key visualisation from the weekly bulletin are included below.

Sources: ERVISS

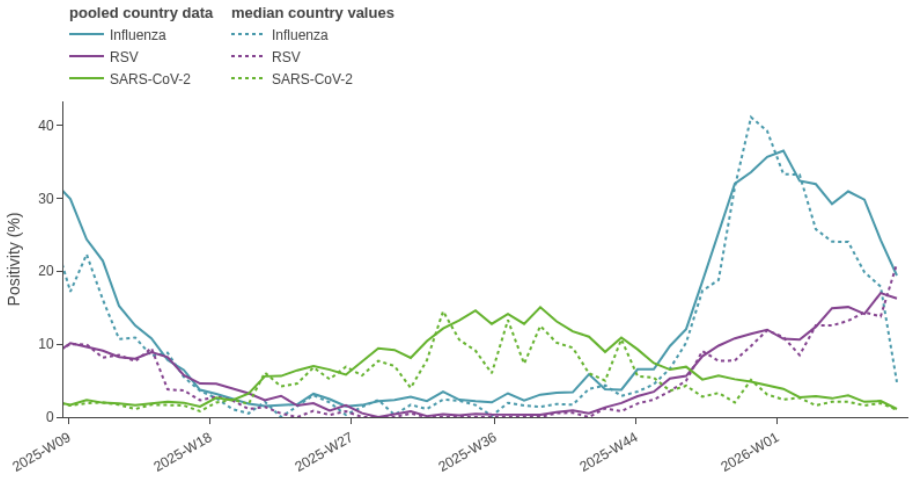
Last time this event was included in the Weekly CDTR: 20 February 2026

Figure 3. ILI/ARI virological surveillance in primary care - weekly test positivity



Source: ECDC

Figure 4. SARI virological surveillance in hospitals - weekly test positivity



Source: ECDC

Figure 5. Key indicators

		Reporting countries		EU/EEA summary	
Indicator	**Syndrome or pathogen**	**Week 8**	**Week 7**	**Description**	**Value**
ILI/ARI consultation rates in primary care	ARI	15 rates (10 MEM)	17 rates (10 MEM)	Distribution of country MEM categories	7 Baseline 3 Low
	ILI	20 rates (18 MEM)	21 rates (19 MEM)		10 Baseline 6 Low 2 Medium
ILI/ARI test positivity in primary care	Influenza	19	21	Pooled (median; IQR)	24% (19; 7–33%)
	RSV	18	20		10% (8.8; 6.1–12%)
	SARS-CoV-2	17	19		2.5% (2.4; 0.2–4.7%)
SARI rates in hospitals	SARI	9 rates (5 MEM)	12 rates (6 MEM)	Distribution of country MEM categories	5 Baseline
SARI test positivity in hospitals	Influenza	7	11	Pooled (median; IQR)	19% (4.8; 3–27%)
	RSV	7	11		16% (21; 13–21%)
	SARS-CoV-2	8	10		1.1% (1; 0–1.1%)
Intensity (country-defined)	Influenza	23	24	Distribution of country qualitative categories	4 Baseline 9 Low 8 Medium 2 High
Geographic spread (country-defined)	Influenza	22	23	Distribution of country qualitative categories	2 Sporadic 6 Regional 14 Widespread

Source: ECDC

Figure 6. ILI/ARI virological surveillance in primary care - pathogen type and subtype distribution

	Week 8, 2026		Week 40, 2025 – week 8, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**436**	**–**	**17155**	**–**
Influenza A	435	100	16643	100
A(H1)pdm09	98	37	3703	27
A(H3)	170	63	10053	73
A (unknown)	167	–	2887	–
Influenza B	1	0.2	75	0.4
B/Vic	0	–	23	100
B (unknown)	1	–	52	–
Influenza untyped	0	–	437	–
RSV	**160**	**–**	**3429**	**–**
RSV-A	19	34	637	49
RSV-B	37	66	659	51
RSV untyped	104	–	2133	–
SARS-CoV-2	**39**	**–**	**3655**	**–**

Source: ECDC

Figure 7. SARI virological surveillance in hospitals - pathogen type and subtype distribution

	Week 8, 2026		Week 40, 2025 – week 8, 2026	
Pathogen	**N**	**%[a]**	**N**	**%[a]**
Influenza	**294**	**–**	**12864**	**–**
Influenza A	30	100	7611	99
A(H1)pdm09	3	50	1191	36
A(H3)	3	50	2136	64
A (unknown)	24	–	4284	–
Influenza B	0	0.0	45	0.6
B/Vic	0	–	4	100
B (unknown)	0	–	41	–
Influenza untyped	264	–	5208	–
RSV	**242**	**–**	**4409**	**–**
RSV-A	15	65	934	55
RSV-B	8	35	749	45
RSV untyped	219	–	2726	–
SARS-CoV-2	**17**	**–**	**2534**	**–**

Source: ECDC

Figure 8. Genetically characterised influenza virus distribution, week 40, 2025 – week 8, 2026

Subtype distribution			Subclade distribution		
Subtype	N	%	Subclade	N	%
A(H1)pdm09	2345	40	5a.2a.1(D.3.1)	2313	99
			5a.2a.1(D)	26	1
			5a.2a(C.1.9.3)	6	0.3
A(H3)	3434	59	2a.3a.1(K)	3091	90
			2a.3a.1(J.2)	233	7
			2a.3a.1(J.2.4)	67	2
			2a.3a.1(J.2.2)	26	0.8
			2a.3a.1(J)	17	0.5
B/Vic	21	0.4	V1A.3a.2(C.5.6)	10	48
			V1A.3a.2(C.5.1)	4	19
			V1A.3a.2(C.5.6.1)	4	19
			V1A.3a.2(C.5)	2	10
			V1A.3a.2(C.5.7)	1	5

Source: ECDC

Figure 9. SARS-CoV-2 variant distribution, week 43, 2024 - week 44, 2024

Variant	Classification[a]	Reporting countries	Detections	Distribution (median and IQR)
BA.2.86	VOI	0	0	0%
XFG	VUM	2	25	64% (50–78%)
NB.1.8.1	VUM	1	2	9% (4–14%)
BA.3.2	VUM	0	0	0%

Source: ECDC

3. Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026

Overview:

Update
Since the previous update and as of 26 February, no major public health events related to communicable diseases have been detected in the context of the Winter Olympic Games.

ECDC continuously monitors this mass gathering event until the end of Winter Paralympic Games.

Summary
The Winter Olympic Games Milano Cortina 2026 finished on 22 February. During the mass gathering event, no major public health events related to communicable diseases were detected. There were limited outbreaks reported among athletes in the Olympic Village. These outbreaks were related to gastrointestinal and influenza-like illnesses. Outside of the Olympic Village, there was no indication of communicable diseases transmission among attendees linked to the attendance to Olympic venues.

Background
The Winter Olympic Games Milano Cortina 2026 took place between 4–22 February 2026. The competition started on 4 February, with the Opening Ceremony on 6 February at San Siro Stadium, Milan and the Closing Ceremony on 22 February at Verona Arena. The Game spread across northern Italy, primarily in Milan and Cortina d'Ampezzo, with additional events in Valtellina, Val di Fiemme, and Anterselva/Antholz. More than 2 900 athletes and participants participated from over 90 countries. Organisers anticipated hundreds of thousands of spectators at the various venues, surpassing one million cumulative attendees.

The Paralympic Winter Games will take place from 6–15 March 2026 with more than 600 athletes competing. The Opening Ceremony will take place at Verona's Olympic Arena. Milan will host the Para ice hockey tournament. Wheelchair curling, Para Alpine skiing and Para snowboard competitions and the Closing Ceremony will be hosted in Cortina. Val di Fiemme will host the Para cross-country skiing and biathlon.

ECDC assessment:

Mass gathering events involve a large number of visitors in one area at the same time. Multiple factors can lead to the emergence of a public health threat, such as an imported disease, increased numbers of susceptible people, risk behaviour, sale of food and beverages by street vendors, etc. At the same time, non-communicable health risks, including crowd or extreme weather-related injuries and drug- and alcohol-related conditions, should also be considered by the organisers and the public health authorities of the hosting country.

The Winter Olympic and Paralympic Games 2026 is a mass gathering involving multiple events in different event locations that take place from February to March. The general assessment provided below refers to the probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games. However, if specific public health events with potential impact at local, national and EU/EEA levels are identified, they will be assessed separately.

The probability of EU/EEA citizens becoming infected with communicable diseases during the Winter Olympic and Paralympic Games 2026 is low, if general preventive measures are applied - e.g. being fully vaccinated according to national immunisation schedules, following advice regarding hand and food hygiene and respiratory etiquette, self-isolating with flu-like symptoms until they resolve, wearing a mask in crowded settings, seeking prompt testing and medical advice as needed, and adopting safer sexual practice. This is particularly important in relation to vaccine-preventable diseases that may be on the rise in the EU/EEA, such as measles, whooping cough, and respiratory infections including influenza and COVID-19. In view of the earlier start of the influenza season

2025/26 in November 2025, ECDC urges those eligible to get vaccinated without delay. ECDC has published recommendations for those attending this mass gathering event.

Actions:

ECDC is monitoring this mass gathering event through epidemic intelligence activities and close collaboration with the Italian National Institute of Health (Istituto Superiore di Sanità) and other partners. Updates with relevant signals and events are being provided on a weekly basis.

Last time this event was included in the Weekly CDTR: 20 February 2026

4. Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles

Overview:

Since November 2025, more than 70 travel-related cases of chikungunya virus disease have been reported by 10 European countries among travellers returning from Seychelles. This represents a marked increase compared with the earlier months of 2025, and no cases have been reported in preceding years.
The emergence of chikungunya virus disease in Seychelles aligns with a broader regional spread throughout the Indian Ocean. Notably, Réunion Island (France) experienced a major outbreak in 2025.
According to local health authorities, chikungunya virus has become more prevalent in Seychelles compared with other circulating arboviruses. For global epidemiological updates, see ECDC's dedicated chikungunya webpage.

ECDC assessment:

The current likelihood of chikungunya virus infection for travellers to Seychelles is high.

Given that the peak travel period to Seychelles occurs between February and April, it is important to strengthen communication to travellers and travel medicine clinics regarding the ongoing outbreak and the need for reinforced preventive measures. Vaccination of travellers may be considered, based on national recommendations.

The likelihood of onward transmission of chikungunya virus in mainland Europe following introduction by a viraemic traveller is currently considered unlikely, as environmental conditions are not favourable for *Aedes* mosquito activity at this time of year.

Actions:

ECDC is monitoring the event through its epidemic intelligence activities. A news item has been published in the ECDC website: High number of chikungunya cases reported among travellers returning from Seychelles: local transmission in mainland Europe currently unlikely. Monthly updates are provided at: ECDC's dedicated chikungunya webpage.

5. Human cases of influenza virus A(H1N1) variant of swine origin - Multi-country

Overview:

In February, authorities in Spain reported a confirmed human case of swine influenza A(H1N1)v. The case, reported from the autonomous region of Catalonia, was confirmed positive for swine influenza by PCR and sequencing. According to the latest available information, the case has no known history of exposure to pigs or a contaminated environment.

Cases of swine influenza have been sporadically reported in Spain and in other countries, the last case being from the autonomous region of Catalonia reported in 2024 (onset of symptoms in 2023). In Spain, a total of four human cases of swine influenza A(H1N1)v have been reported in the last 17 years, and no human to human transmission has been identified to date.

A sample taken as part of the acute respiratory infections surveillance system tested positive for influenza A. Subsequent testing was positive for swine influenza A(H1N1)v at the reference laboratory of the autonomous region of Catalonia.

The case remains asymptomatic, while epidemiological investigations are still ongoing.

ECDC assessment:

Sporadic human cases infected with influenza virus of swine origin have previously been reported from several countries globally, including in the EU/EEA. The exposure to infected pigs represents the most common source of infection in humans. Limited, non-sustained human-to-human transmission of variant influenza viruses has previously been documented, although it remains a rare event.

Based on the information currently available, the likelihood of further transmission in human of variant A(H1N1) linked to this event is assessed to be very low. This assessment will be updated if additional relevant epidemiological information becomes available.

Novel influenza viruses in humans, including zoonotic influenza viruses, should be further characterised, as well as shared with the national influenza reference laboratories and World Health Organization (WHO) Collaborating Centres. All cases need to be thoroughly followed up to exclude human-to-human transmission and implement control measures.

Actions:

ECDC monitors zoonotic influenza events through its epidemic intelligence activities and disease experts in order to identify significant changes in the epidemiology of the virus. Human cases of infection with zoonotic influenza virus in the EU/EEA should immediately be reported to the Early Warning and Response System (EWRS) and International Health Regulations (IHR).

ECDC guidance: Testing and detection of zoonotic influenza virus infections in humans in the EU/EEA, and occupational safety and health measures for those exposed at work; Surveillance and targeted testing for the early detection of zoonotic influenza in humans during the winter period in the EU/EEA.

Last time this event was included in the Weekly CDTR: 9 January 2026

Events under active monitoring

- Cholera – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Overview of respiratory virus epidemiology in the EU/EEA
- Bacillus cereus toxin in infant formula
- Nipah virus disease – India and Bangladesh – 2026
- Travel-associated chikungunya virus disease in EU/EEA countries imported from Seychelles
- Human cases of influenza virus A(H1N1) variant of swine origin - Multi-country
- Mass gathering monitoring – Winter Olympic and Paralympic Games in Milan – 2026
- Mpox clade Ib and clade IIb recombinant strain
- Avian influenza A(H10N3) – Multi-country (World) – Monitoring human cases
- Mpox in the EU/EEA, Western Balkans and Türkiye – 2022–2026
- Measles – Multi-country (World) – Monitoring European outbreaks – monthly monitoring
- Dengue – Multi-country (World) – Monitoring global outbreaks – Monthly update
- Rapid Outbreak Assessment under production
- Chikungunya virus disease – Multi-country (World) – Monitoring global outbreaks – Monthly update
- SARS-CoV-2 variant classification
- Middle East respiratory syndrome coronavirus (MERS-CoV) – Multi-country – Monthly update
- Mpox due to monkeypox virus clades I and II – Global outbreak – 2024–2026